

**Summary of Medical Services Fund Advisory Council Meeting
July 15, 2005
1:30 p.m.
Kanawha Valley Senior Services**

Members Present

Violet Burdette, Chairperson, Primary Care Representative
Charlie Young, Alternate, Bureau for Children and Families
Charles Covert, Hospital Representative
Jesse Samples, Nursing Home Representative
John Mullins, Alternate, Nursing Home Representative
Scott McClanahan, Aging Program Representative
John Russell, MH/BH Representative
Cathy Taylor, Alternate, Bureau for Public Health
Mark B. Ayoubi, Physician Representative
Gerry Stover, Alternate, Physician Representative
Michael Kilkenny, Physician Representative
Mike Robbins, Alternate, Hospital Representative

Bureau for Medical Services Staff Present

Nancy Atkins, Commissioner
Randy Myers
Shelley Baston
Auburn Cooper
Pat Miller
Steve Mullins

Interested Parties

LuAnn Summers, DRS
John Marks, WVMI
Brian Cunningham, WV Primary Care Assoc.
Amanda Hiser, Unisys
Gary Knight, CMS
Bill Lytton, BOSS
Thom Stevens, Government Relations Specialist

I. Welcome and Opening Remarks

Nancy Atkins presented a Certificate of Appreciation plaque to Auburn Cooper, as he is retiring from the Bureau for Medical Services and this will be his last time with the Medical Services Fund Advisory Council.

II. Approval of Minutes for the MSFAC Meeting of April 22, 2005

There was a motion made by Dr. Ayoubi to accept the minutes from the April 22, 2005 meeting as written. Charlie Young seconded that motion. All were in favor.

Violet Burdette stated that, in response to the April 22nd minutes, the letter that we discussed was sent to the Governor's Office; however, we have received to response.

III. Medicaid Cost Containment Initiatives

Nancy Atkins acknowledged that Gary Knight from CMS was at the meeting. Nancy reviewed the numerous Medicaid cost containment initiatives.

Violet Burdette requested a copy of the handout that Nancy used for giving this report be provided to the group.

There was some discussion on the cuts and the difficulties it poses for practices and for referral services.

IV. Budget Status

As Tina Bailes was unavailable to attend, there was no information.

Mike Robbins made a request that rather than wait until our next quarterly meeting, that a final 2005 year end financial report be sent to the council members.

V. MMIS Implementation (Unisys) Update

Amanda Hiser from Unisys provided information on the workshops which were held on June 7 – 18, 2005. Providers had some concerns with crossovers. Amanda stated that claims are being received from all three intermediaries now, which started mid to late June. All files from Administar and about 130,000 of the Palmetto files have been processed. UGS is still being worked on and have not been processed yet. Work on this project continues.

Amanda stated that as far as electronic filing is concerned, files are being received from a couple of clearing houses now, and other ones are testing with us, so providers who were complaining about having to bill on paper before do not have to do so anymore.

Also, Unisys is receiving crossovers electronically using the web portal for any providers who are interested. As of July 7, 2005 providers can bill not only crossovers to the web portal for professional claims, but they can also bill TPL Primary Claims. Professional claims can also be billed through the web portal.

Unisys continues to meet on a weekly basis with the Behavioral Health Providers, meets with the Hospital Association every two weeks, meets with the RHC/FQHCs upon request, and the Nursing Home calls are every two weeks.

Remittance Advice and the Claims Process Reports are available to all providers.

Unisys has posted the reprocessing schedule on the web.

Pat Miller stated that the remittance advice has changed. Unisys now prints on the remittance if a member is in an HMO, the name of the HMO, or if they have a PAAS provider. The ability to see the member ID number that the provider billed vs the ID number it may have paid over has also been added.

Amanda stated that there is a sheet in the handout consisting of a compilation of all the remittance advice changes the providers have suggested to Unisys. Some of them have been completed, but others are still being reviewed. Amanda wants to let providers know that these are the top requests that Unisys had for changes in the remittance advice and which ones are being reviewed as a change.

Charles Covert had the following issues:

1) Medicaid cards are showing that a patient is straight Medicaid, but when the provider bills for the service, the claim is denied and they find that it is really an HMO patient.

Pat Miller stated that this is still an ongoing problem. Unisys is doing some validation procedures. They are putting those in place so that every month the file that will be validated is sent to make sure that the most current PCP information is being transmitted, and they are validating with Rapids that they are using the correct fields out of that file to print on the card.

2) Providers do not get a pended claims list anymore.

Amanda stated that this is the Claims in Process Report that she referred to previously. It goes out every Friday, and is located where the remittance advice is downloaded.

3) Crossover claims are being shown as denied instead of zero payment, which causes a problem when trying to put them on a Medicare crossover log. They are not denied, it is just that nothing is being paid.

Amanda stated she would talk with Charles Covert. She said they are working on a remit message stating zero dollars paid means that the primary payer paid more than was allowed.

VI. MR/DD Waiver Renewal / AD Waiver Renewal

Steve Mullins said that the MR/DD and AD Waivers were submitted to the federal government on June 30, 2005 in hopes of getting a decision by the end of September. If or when they are approved, year one will begin July 1, 2005. The Bureau for Medical Services had put the Waivers out for additional comment from stakeholders, and conducted with mixed reviews some additional forums around the State to allow people to make additional comments and react to any changes that we had made from the last time we put them out for comment. The big change in the MR/DD Waiver that was made since the last Medical Services Fund Advisory Council meeting is that we decided to move directly to, with APS Healthcare's assistance, an individual budget methodology.

The other changes that have been proposed in this Waiver that are different from what people are getting right now are not very significant. One service is being added, and that is a crisis component. This is mainly to avoid having to hospitalize people when they are in crisis, and would just allow us to prior authorize intensive in-home services over and above what a person could normally receive in order to stabilize a person in

crisis in their home. Otherwise, the plan is to replicate all of the services that are in the Waiver now.

Steve stated that when we get down to the writing of the Program Manual, we may find ourselves reimbursing differently, creating per diems in some cases for providers rather than making them document and bill on 15 minute increments. We may also put service limits that are different from those that exist now, but generally speaking, the MR/DD Waiver for the next year will pretty much look like it does now. However, some new assessments will be implemented that APS Healthcare will conduct in order to build a data base that will allow us at the end of the year to have these people on an individual plan and individual budget.

Steve Mullins stated that the biggest change in both of these Waivers from the standpoint of access is that we aren't envisioning serving any more people than we currently have, and in fact, in this Aged and Disabled waiver, we are reducing the number of people going forward down to an amount that we feel can be funded out of the Lottery appropriation that we receive for this program. Steve stated that we receive \$13 million of lottery funds, and we turn that into about \$51 million when we draw federal funds. We've been spending several million more than that \$51 million to serve 5,400 people, so we're ratcheting that down at the Secretary's request to try to live within the lottery appropriation. That means this year we will serve about 3,900 people. After one year, we think attrition will take it down to around 3,450 people, which is what we calculate can be afforded within the \$51 million that's available annually for this program.

Steve Mullins stated that the big change in the AD Waiver is where the client himself, if he wishes, can become the employer of his in-home staff. He can hire, fire, and become the employer of record. That carries with it the obligation to pay taxes and so forth. In order to do that there is a grant from Robert Wood Johnson that would allow us to develop infrastructure. This is being funded by the Robert Wood Johnson Grant that the Bureau of Senior Services has received for self directed services. We would have some intermediary that would take care that the taxes were paid, make payroll for them, and make any other purchases that are a legitimate use of the Waiver funds. All of this being revenue neutral. There will be a cost, of course, to pay the intermediary, but that will come from what we are currently spending on services. Steve stated that he feels that as many as 10% of the participants in this Waiver might eventually express a desire to manage their own affairs. Steve also believes that we can get this started in the Aged and Disabled Waiver and hopefully take it into the MR/DD Waiver at some point, because there is quite a demand for this kind of self-directed services in that Waiver, and it could even be used for some state plan services like personal care, if the State were to decide to roll it out that far. There was some discussion on this subject.

Steve Mullins stated that the documents that are in the packets are companion documents to the actual applications that we filed. Those are also on the BMS website.

VII. Other Issues

Nancy Atkins stated that we attempted to have a representative from CMS here at the meeting to make a presentation about the Medicare Modernization Act, Pharmacy Part D, but were not able to facilitate this. She now plans to have a representative from CMS come in October to do an abbreviated presentation.

There was some discussion on this subject.

VIII. Conclusion

Violet Burdette stated that the Medical Services Fund Advisory Council needs to send a follow-up letter to Governor Manchin. A suggestion was made to carbon copy it to Bob Kiss, Speaker of the House of Delegates, and Earl Ray Tomblin, Senate President.

The next meeting of the Medical Services Fund Advisory Council is October 14, 2005.

A motion was made and seconded to adjourn the meeting. All were in favor.

Respectfully Submitted By:

Pat Johnson
Secretary